STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003915	A. BUILDING: _____ B. WING _____	08/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN PARK ASSISTED LIVING COMMUNITY	5045 W 52ND ST INDIANAPOLIS, IN 46254

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Licensure Survey. Survey dates: August 26 and 27, 2013. Facility Number: 003915 Provider Number: 003915 AIM Number: NA Survey Team: Jeanna King, RN- T.C. Lora Brettnacher, RN Shannon Pietraszewski, RN Census bed type: Residential: 50 Total: 50 Census payor type: Medicaid: 39 Other: 11 Total: 50 Sample: 7 Autumn Park Assisted Living Community was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure Survey. Quality Review 08/28/13 by Lisa McColly	R 000		